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The Effects of Ethnicity and Characteristics of Practitioners on Disclosure of Sexually Sensitive Information

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Abstract

Purpose: The CDC (Centers for Disease Control and Prevention [CDC], 2010) reports 19 million new sexually transmitted infections (STIs) each year. It is vital that patients fully disclose their sexual health history and concerns to healthcare practitioners in order to receive appropriate care; yet data suggests that patients do not fully disclose sexual health information to their healthcare practitioners (Sankar & Jones, 2005). Patients cite practitioner characteristics (age, gender, and ethnicity) as one barrier to disclosing sexual health information (Gott & Hinchliff, 2003; Sankar & Jones, 2005). The purpose of this secondary analysis is to extend these findings and examine the relationship between ethnicity and the practitioner characteristics of gender, ethnicity and practitioner role on patients' likelihood to fully disclose sexual health information. **Methods:** This secondary analysis is part of a parent study examining the relationship between ethnicity, ethnic identity, and tolerance of infidelity among college women at risk for HIV. The sample for this and the larger study was from a large Midwestern university. The sample consisted of 78 African- and European-American sexually active female college students (ages 18 – 30 years). All undergraduate women in the university's system received an electronic newsletter advertising the study. Interested women contacted the PI for study information. Those interested in the study accessed secure, online questionnaires. For this analysis questionnaires about ethnic identity and disclosure of sexual health information to health care practitioners (nurse or physician) who vary in gender (female or male) and ethnicity (African- or European-American). Data were analyzed using descriptive statistics and t-tests. **Conclusions:** Both African American and Caucasian women preferred female providers regardless of practitioner role or race. African American women reported more sensitivity to practitioner race and gender than Caucasian women. Patients comfort level with disclosing sexual health information should

be assessed in an attempt to match them with a provider they are most comfortable with in order to encourage complete and honest disclosure of sexual health information.

The Effects of Ethnicity, Ethnic Identity, and Characteristics of Practitioners on Disclosure of Sexually Sensitive Information

The CDC reports that the U.S. healthcare system spends 16.4 billion annually on the treatment of STIs (Centers for Disease Control and Prevention [CDC], 2010). Ethnic minorities, especially young African American women aged 15-24 years old, are most affected by STIs (CDC, 2010). Left untreated STIs increase the risk for HIV and can cause serious complications, such as infertility. The CDC finds that 24,000 women suffer from infertility annually as the result of untreated STIs (CDC, 2010). Every effort must be made to encourage patient comfort in accessing and sharing sexual health information with healthcare providers so that they receive appropriate care and prevent serious complications

Several studies have reported that patients do not fully disclose their sexual health information to their healthcare providers (Dunn, Croft, & Hackett, 1998; Farber, 2003; Gott & Hinchliff, 2003; Schwartz, 2010). A widely cited WebMD survey revealed that 17% of respondents lied to their physician about topics surrounding sex, and that younger patients aged 25-34 are more likely to lie about their sexual history than older adults (Schwartz, 2010). The CDC (2010) recommends screening high-risk sexually active women for common sexually transmitted infections (STIs), as there are 19 million new STIs reported annually. However, in order for patients to be appropriately screened and treated for STIs, patients must fully disclose their sexual health history and concerns to healthcare providers as their care plan and treatment is determined by the behaviors they report (Ginige, Chen, & Fairley, 2006; Sankar & Jones, 2005).

Practitioner characteristics, such as practitioner gender and race, have been cited as barriers for patients in disclosing sexual health information (Chur-Hansen, 2002; Dunn et al., 1998; Farber, 2003; Gott & Hinchliff, 2003; Julliard, Vivar, Delgado, Cruz, Kabak, & Sabers, 2008;

Sankar & Jones, 2005; Sarkadi & Rosenqvist, 2001). Research on the influence of practitioner characteristics on patient's self-disclosure of sexual health information is varied. Some research identifies practitioner gender as having significant influence on patients willingness to disclose sexual health information (Chur-Hansen, 2002; Dunn et al.,1998; Julliard et al., 2008; Kerssens, Bensing, & Andela, 1997; Sankar & Jones, 2005; Sarkadi & Rosenqvist, 2001; Schmittdiel, Selby, Grumbach, & Quesenberry, 1999), while other research shows practitioner gender as having little to no influence on patients comfort and self-disclosure level (Cooper-Patrick, Gallo, Gonzales, Vu, Powe, Nelson, & Ford, 1999; Howell, Gardiner, & Concato, 2002; Ginige et al., 2006; Street, O'Malley, Cooper, & Haidet, 2008). Patient-practitioner race concordance has been identified as having an influence on patient involvement and satisfaction with care, but little has been studied on the specific influence of patient-practitioner race concordance in encouraging full disclosure on sexually sensitive topics. Also neglected in current research is the influence of practitioner role (physician versus nurse) on patient disclosure. Receiving the preferred practitioner in terms of race or gender has been shown to increase patient satisfaction with care and improve outcomes (Cooper-Patrick et al., 1999; Schmittdiel et al., 1999; Street et al., 2008).This study examines the effect that ethnicity and the practitioner characteristics of gender, race, and practitioner role has on patients' likelihood to fully disclose sexual health information.

While it is encouraging that some studies report patients are willing to disclose sensitive sexual health information (Gerbert et al., 1999; Sankar & Jones, 2005), other studies indicate that patients are generally less than forthcoming in regard to topics concerning their sexual health (Cochran & Mays, 1988; Dunn et al., 1998; Farber, 2003; Gott & Hinchliff, 2003; Schwartz, 2010; Steedman & Clutterbuck, 2007). Patients suffering from sexual issues often want to seek help and treatment for their problem, but few actually ever ask and thus receive the desired care

(Dunn et al., 1998; Farber, 2003; Gott & Hinchliff, 2003; Gott, Galena, Hinchliff, & Elford, 2004). Practitioner characteristics, such as practitoner gender and race/ethnicity, have been cited by patients as barriers to disclosure, along with feelings of shame, perception that the sexual problem was not serious enough to discuss, and lack of time and privacy in office visits (Farber, 2003; Gott & Hinchliff, 2003; Julliard et al., 2008; Sankar & Jones, 2005). Sankar and Jones (2005) found that women reported being most comfortable with, and thus more likely to disclose information, to physicians who were of a similar age, gender, language, and race/ethnicity. Patients are not the only party resisting discussing sexual health topics, as healthcare practitioners also find discussing sensitive sexual health topics with patients challenging (Chur-Hansen, 2002; Dunn et al., 1998; Ekstrom, 1999; Haboubi & Lincoln, 2003; Hinchliff, Gott, & Galena, 2004; Howell et al., 2002; Ginige et al., 2006; Gott, Galena, Hinchliff, & Elford, 2004; Julliard et al., 2008; Kerssens et al., 1997; Roter & Hall, 2004; Sarkadi & Rosenqvist, 2001; Schmittdiel et al., 1999; Stokes & Mears, 2000). Practitioners report that lack of time, embarrassment, lack of training, and patient characteristics such as patients of an older age, the opposite gender, a different sexual orientation, and patients from African American or ethnic minority groups present barriers to their sexual health discussions with their patients (Haboubi & Lincoln, 2003; Hinchliff et al., 2004; Gott et al., 2004; Stokes & Mears, 2000).

Literature on the influence of gender concordance in the physician-patient relationship on patients' disclosure of sexual health information is varied. Women, especially younger women, report more comfort in discussing their sexual health with female practitioners (Chur-Hansen, 2002; Dunn et al., 1998; Julliard et al., 2008; Kerssens et al., 1997; Sankar & Jones, 2005; Sarkadi & Rosenqvist, 2001; Schmittdiel et al., 1999). The majority of research on women's preferences for the gender of their practitioner indicates a greater preference for female

practitioners in more intimate clinical situations such as obstetrics and gynecology (Chur-Hansen, 2002; Dunn et al., 1998; Julliard et al., 2008; Kerssens et al., 1997; Schmittdiel et al., 1999). Research also shows that female patients are more likely to prefer a practitioner of the same gender than male patients (Chur-Hansen, 2002; Kerssens et al., 1997). Patients of both genders have also been found to disclose more overall to female practitioners (Roter & Hall, 2004; Roter, Hall, & Aoki, 2002). Female physicians also held longer patient visits and performed more preventative counseling and screening than male physicians did (Roter & Hall, 2004, Roter et al., 2002). Alternatively, some research finds practitioner gender to have no effect on patients' comfort or willingness to disclose or communicate sexual health information with their practitioner (Cooper-Patrick et al., 1999; Howell et al., 2002; Ginige et al., 2006; Street et al., 2008). A study by Ginige, Chen, and Fairley (2006) showed that practitioner gender had no significant influence on patients responses to sensitive sexual health questions (Ginige et al., 2006). Another study by Howell, Gardiner, and Concato (2002) reported that a majority of women in their sample had no gender preference for their obstetrician, valuing instead the obstetricians' interpersonal style and technical expertise (Howell et al., 2002). However the women did indicate a preference for female nurses (Howell et al., 2002). Also, gender concordance between African Americans and their practitioners was not shown to significantly improve practitioner-patient communication and patient satisfaction (Cooper-Patrick et al., 1999; Street et al., 2008).

Race concordance in the patient-physician relationship has been investigated as a possible influence on patient communication, participation in care, and satisfaction, but research on race concordance influencing disclosure of sensitive sexual health information is limited. The literature on race concordance in the patient-physician relationship shows that African

Americans are more satisfied and more participatory in care provided by practitioners of the same race (Cooper, Roter, Johnson, Ford, Steinwachs, & Powe, 2003; Cooper-Patrick et al., 1999; Johnson, Roter, Powe, & Cooper, 2004; LaVeist & Carroll, 2002; Street et al., 2008). Street, O'Malley, Cooper, and Haidet (2008) reported that when patients sense they are similar to their practitioners in terms of beliefs and values, it results in an increase in patient satisfaction and intention to adhere to treatment plans. Race concordance between the patient and physician was identified as the most influential aspect of patients feeling similar to their practitioner (Street et al., 2008).

Neglected in current research is the influence that practitioner role (physician versus nurse) has on patients' willingness to disclose sexual health information. Even more than practitioner gender, women value interpersonal skills and expertise in the practitioner responsible for their sexual health (gynecology and obstetrics) (Howell et al., 2002; Sarkadi & Rosenqvist, 2001; Schmittdiel et al., 1999). In a study by Schmittdiel et al. (1999) women preferred to see a gynecologist over a nurse practitioner or their primary care provider for basic gynecological care. Almost half the women in the study indicated no preference for practitioner gender, making it clear that while practitioner gender was an important factor for some, practitioner type or expertise was more valued overall (Schmittdiel et al., 1999). Moreover, when patients' preferences for either practitioner gender, race, or role are met, patient satisfaction and outcomes are improved (Cooper-Patrick et al., 1999; Schmittdiel et al., 1999; 33). Schmittdiel et al. (1999) reported that women who did not see a practitioner of their preferred gender or type at their last gynecological visit were more likely to have had their last examination over 2 years ago.

With such a high number of STIs plaguing the country, disclosure of sexual risk behaviors to health providers must be complete and accurate so that the appropriate screening,

treatment, and care can be provided. Practitioner gender, race, and role appear to have some influence on patients' openness in disclosure and communication with practitioners. The exact effect of practitioner race and role on patients' disclosure of sexual health information is an understudied area. This study aims to examine the influence that practitioner characteristics of gender, ethnicity, and role has on patients' willingness to fully and accurately disclose their sexual health information and if there are differences by ethnicity of the participant. Research questions include:

a) What are levels of disclosure based on ethnicity, gender, and role of the practitioner?

c) Are there differences between African-American and Caucasian respondents in willingness to disclose?

Method

This secondary analysis is part of a parent study examining the relationship between ethnicity, ethnic identity, and tolerance of infidelity among college women at risk for HIV.

Sample

The sample for this and the larger study was from The Ohio State University. The sample consisted of 78 African- -American and Caucasian sexually active college women (ages 18 – 30 years). Inclusion criteria are: female, heterosexual, African American or Caucasian, current college student, between the ages of 18-30, not married, able to speak, read, and write English, and sexually active.

Procedure

After institutional review board approval, all undergraduate women in the university's system received an electronic newsletter advertising the study and an additional study advertisement was sent to the African American listserv. Flyers were also distributed to campus buildings

advertising pertinent study information. Interested women contacted the Primary Investigator (PI) for further study information via e-mail. Once interested subjects contacted the PI via their OSU buckeyemail email account, which ensured that the participant was an OSU student, they were directed to the website containing the survey. All emails addresses and names were deleted after instructions to the website and survey were given. Those interested in the study accessed secure, online questionnaires through the university's learning management system which allows only the participants and the PI to access the data. Survey responses were anonymous, and the consent form was the first screen of the survey. Once the participants consented to the study they responded to the study questionnaires. After completing the survey, the participants viewed a debriefing message along with instructions on how to collect their five dollar incentive for participation.

Measures

Ethnicity. Ethnicity of the participants was measured through responses to a demographic section of the survey which asked that participant to indicate which ethnic group the considered themselves to be a part of. Participants were also asked the ethnicity of their father and mother.

Disclosure to Practitioner. Participants comfort level in disclosing sexual health information to a nurse or a physician of a different or similar race or gender was assessed through the use of an investigator-developed scale. The scale allows participants to rate their comfort level with disclosing sexual health topics with various types of practitioners. On a scale of 1-5 (1- being not at all comfortable and 5- being extremely comfortable) participants rated their comfort level in discussing their sexual history with an African American female doctor, Caucasian female doctor, African American male doctor, Caucasian male doctor, African

American female nurse, Caucasian female nurse, African American male nurse, or Caucasian male nurse.

Data Analysis

Results were analyzed using descriptive statistics and t-tests.

Results

The sample consisted of 78 African American (34.6%) and Caucasian (65.4%) women. All women were unmarried, sexually active in the past 3 months, and current college students.. Table 1 summarizes the average comfort level of the women in discussing their sexual health history with a nurse or a physician of a different or similar race or gender.

African American Male/Female Nurse: African American women were less comfortable (comfort level of 4.22 out of 5) than Caucasian women (comfort level of 4.63 out of 5) discussing their sexual history with an African American female nurse (p=.04). Both African American and Caucasian women reported decreased comfort in discussing their sexual history with an African American male nurse, but African American women remained less comfortable with the discussion reporting an average comfort level of 1.89 while Caucasian women reported an average comfort level of 2.61 (p=.02).

Caucasian Male/Female Nurse: In discussions on sexual history with a Caucasian female nurse African American women remained less comfortable (3.93) than Caucasian women (4.67) (p=.00). Both African American and Caucasian women again reported decreased comfort in discussing their sexual history with an Caucasian male nurse, but African American women yet again remained less comfortable with the discussion reporting an average comfort level of 1.78 while Caucasian women reported an average comfort level of 2.71 (p=.00).

African American Male/Female Physician: A nonsignificant (p=.06) difference in comfort level was reported between African American and Caucasian women in discussing their sexual history with an African American female physician. African American women reported a comfort level of 4.33 and Caucasian women reported a comfort level of 4.67 with the African American female physician. However, there was a significant difference (p=.04) noted between the women for the sexual history discussion with an African American male physician. With the African American male physician the African American women again reported less comfort (2.04) in the discussion than the Caucasian women (2.69).

Caucasian Male/Female Physician: African American women were less comfortable (4.07) than Caucasian women (4.69) discussing their sexual history with a Caucasian female physician (p=.00). Both African American and Caucasian women once more reported decreased comfort in discussing their sexual history with an Caucasian male physician, but African American women were more comfortable with the discussion reporting an average comfort level of 1.89 while Caucasian women reported an average comfort level of 1.35 (p=.00).

Table 1 summarizes the average comfort level of the women in discussing their sexual health history with a nurse or a physician of a different or similar race or gender.

Discussion

The results of this study replicate other findings that find a resistance to disclose sexually sensitive information to practitioners based upon gender and ethnicity (Chur-Hansen, 2002; Dunn et al.,1998; Farber, 2003; Gott & Hinchliff, 2003; Julliard et al., 2008; Sankar & Jones, 2005; Sarkadi & Rosenqvist, 2001); however, it extends those findings by examining willingness to disclose to nurses as compared to physicians. Overall, African American women reported a greater sensitivity to practitioner race and gender when discussing their sexual history. Caucasian

women were more comfortable discussing their sexual history than African American women with all variations of practitioners with the exception of the Caucasian male physician. Both Caucasian and African American women preferred a female provider regardless of practitioner role or race. In terms of practitioner role both African American and Caucasian women generally preferred a physician to nurse regardless of gender or race, with exception of the Caucasian women who reported more comfort with a Caucasian male nurse versus Caucasian male physician. Both races of women reported the most comfort discussing their sexual history with a female physician of their own race.

Patients comfort level with disclosing sexual health information to a particular practitioner should be assessed in an attempt to match patients with a provider they are most comfortable with in order to encourage complete and honest disclosure of sexual health information. It is evident that the characteristics of the practitioner can influence patients' disclosure of sexually sensitive information; therefore, this influence must be acknowledged and addressed when possible. The ideal matching of practitioner to patient based on the patient's preferred practitioner characteristics is obviously not always possible or realistic. However, practitioners should be aware of the possible implications that their personal characteristics have on their patient interactions. In patient-practitioner interactions that are not ideally matched in terms of practitioner gender, race, and provider role it is vital for the practitioner to be aware of and acknowledge the potential barriers to disclosure. Healthcare practitioners must work through these barriers to disclosure and encourage and educate their patients on the importance of fully disclosing their sexual health information so that the best care can be provided. Further research should focus on the effect of healthcare providers interpersonal communication skills in fostering successful patient disclosure of sexual health information. It is possible that the difficult to

control practitioner characteristics of gender, race, and practitioner role that act as barriers to disclosure may be overcome by employing effective interpersonal communication skills that encourage disclosure during the practitioner-patient interaction.

Limitations to this study include the use of a convenience sample and the focus on African American and Caucasian women only. Future research should include other races/ethnicities and assess the comfort levels of men as well as women in discussing sexual health issues with healthcare providers. Also neglected in this study is the role of the patient's culture on their practitioner preference. Different cultures within the general population, especially within the African American race demographic, influence patients' preference for practitioner gender in particular. The role of culture in patients' practitioner preferences needs to be evaluated as part of the assessment of practitioner characteristics that present barriers to patient disclosure of sexually sensitive information.

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Table 1

Average Comfort Level with Sexual History Conversation by Various Practitioners

Comfortable discussing sexual history with :	**African-American *M*(*SD*)**	**Caucasian *M*(*SD*)**	***p***
African American Female Nurse	4.22 (.89)	4.63 (.56)	.04
African American Male Nurse	1.89 (1.25)	2.61 (1.31)	.02
Caucasian Female Nurse	3.93 (1.0)	4.67 (.55)	.00
Caucasian Male Nurse	1.78 (1.09)	2.71 (1.32)	.00
African American Female Physician	4.33 (.78)	4.67 (.55)	.06
African American Male Physician	2.04 (1.26)	2.69 (1.35)	.04
Caucasian Female Physician	4.07 (.87)	4.69 (.55)	.00
Caucasian Male Physician	1.89 (1.07)	1.35 (.19)	.00